NJ STATE HEALTH BENEFITS RETIRED STATUS APPLICATION

New Jersey Division of Pensions and Benefits
P.O. Box 299 • Trenton NJ 08625-0299

1. APPLICANT INFORMATION

Social Security Number ___ - ___ - ____

Last Name _____ Title (Jr., Sr., etc.) ___

First Name _____ Middle Name _____

Street Address _____ Apartment # ____

PO Box ____ City _____

State __ Zip Code + 4 _____ - ____

Date of Birth mm dd yyyy 1 9 ____ Gender - M F

Marital Status (check one) ☐ - Single ☐ - Married ☐ - Divorced ☐ - Widowed

Area Code ___ - Home Telephone Number ___ - ____

Date of Retirement mm 0 1 dd ____ yyyy ____

Were you a part time employee when you retired ? ☐ - Yes ☐ - No

From which employer did you retire? _____

2. TYPE OF ACTIVITY — Check one box in Section A; if you select ***New Retiree, Cancel Coverage***, or ***Survivor Enrollment,*** skip to Part 3 Member Selection. If you select ***Coverage Change****, complete Section B; if you check Other, complete Section C.*

A. ENROLLMENT ACTION REQUESTED

☐ - New Retiree ☐ - Survivor Enrollment
Give Decedent's SS# _____

☐ - Cancel Coverage ☐ - Coverage Change ☐ - Other Change

B. COVERAGE CHANGES

Plan Change - From - To

	MONTH	DAY	YEAR
Marriage (Give Date)			
Former Name			
Birth of Child (Give Date)			
Adoption/Guardianship - Proof Required (Give Date)			
Deletion of Dependent (Give Event Date)			

Give Dependent's name: _____ SS#: _____

Reason for Deletion: ☐ Death of Spouse ☐ Divorce ☐ Separation ☐ Other _____

C. OTHER CHANGES

☐ Change In Last Name Only
(Give Former Name) _____

☐ Correction to Social Security # - Attach copy of Social Security Card
(Give Former Social Security #) _____

☐ Change In Birth Date (Give Name and Correct Date) - Attach copy of Birth Certificate
_____

☐ Addition of dependent's Social Security # (List the dependent(s) In section 5)

☐ Other: Give Reason Below *(i.e.*, address change, dependent returns from military service, etc.)
_____
_____

EARLY RETIREMENT INCENTIVE PROGRAM

3. PLAN SELECTION (Check one box only).

☐ I wish to be covered under NJ PLUS.
Your primary care physician's ID # _____

☐ I wish to be covered under an HMO.
Name of HMO and # _____
Your Primary Care Physician's Name or # _____

☐ I wish to be covered under the Traditional Plan

I do not wish to be covered under any of the medical plans for the following reason:

☐ I have coverage under my spouse Spouse's Employer _____
☐ I have coverage with another employer List Employer _____
☐ Other (Give Reason): _____

4. LEVEL OF COVERAGE (Check one box and indicate if you, your spouse, or eligible children have Medicare coverage).

☐ - Single ☐ - Member & Spouse ☐ - Family ☐ - Parent/Child(ren)

	YES	NO	EFFECTIVE DATE MONTH	DAY	YEAR
Do **YOU** have Medicare Part A? (Hospital Insurance)					
Do **YOU** have Medicare Part B? (Medical Insurance)					
Does **YOUR SPOUS**E have Medicare Part A?					
Does **YOUR SPOUSE** have Medicare Part B?					
Does **YOUR ELIGIBLE CHILD** have Medicare Part A?					
Does **YOUR ELIGIBLE CHILD** have Medicare Part B?					

If yes, list child's name and Social Security #: _____

Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program.

If enrolled, a photocopy of the Medicare card must be submitted with application.

5. SPOUSE AND DEPENDENT INFORMATION — List eligible dependents you wish to include on your coverage. If necessary, attach another sheet of paper.

	Last Name	First Name	MI	Date of Birth (mm,dd,yyyy)	Gender	Social Security Number	Dependent's HMO primary care physician or NJ PLUS physician ID #	Natural (C) Adopted (A) Foster (F) Stepchild (S)
Spouse								
Eligible Children								

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Event Reason ☐ Eff. Date ____

Location No. ____ Bureau No. ____ Fund ____ Ret. Code ____ Retirement No. ____

Mo. of Service ____ Process Date ____ Processed by _____ (initial here)

6.

I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a pension deduction from my pension check as required by the State Health Benefits Commission. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the HMO and NJ PLUS programs. I authorize any hospital, physician, or health care provider to furnish the HMO or its assignee with such medical information about myself or my covered dependents on this application, as the HMO or assignee may require. **Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. PROOF OF ENROLLMENT IS REQUIRED.** If you enroll in Medicare at a later date, the Health Benefits Bureau must be notified immediately.

APPLICANT'S SIGNATURE _____ **DATE** _____

ADDITIONAL SHEET ATTACHED ☐

MEDICARE PROOF ENCLOSED ☐

WHITE COPY— HEALTH BENEFITS BUREAU, CANARY COPY — MEMBER

COMPLETING THE RETIRED STATUS APPLICATION

SECTION 1 — APPLICANT INFORMATION

This section pertains to the person enrolling in the retired group. Complete all requested information, filling in one letter or number per block. Provide Date of Birth and Date of Retirement (for example: April 12 1933 = 04 12, 1933) for month, day, and year. Lastly, list the employer from which you have retired. Please indicate if you were a part-time employee.

SECTION 2 — TYPE OF ACTIVITY

Check one box in section A. If you are just retiring check the first box "New Retiree". Coverage can be voluntarily cancelled at any time by checking "Cancel Coverage." Reinstatement into the program, however, is not normally permissible.

If you are enrolling in the program as a Surviving Spouse/Dependent, check "Survivor Enrollment."

If you checked "Coverage Change" enter the change information in section B; if you checked "Other" enter the change information in section C.

SECTION 3 — PLAN SELECTION

Check only one appropriate box indicating which plan you would like to join or that you do not want coverage. When choosing an HMO or NJ PLUS you must list the identification number (ID #) of your Primary Care Physician. If you are declining coverage and do not want the State Health Benefits Program, check one of the boxes under "I do not wish to be covered under any of the medical plans." If you select "Other," give the reason. If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP medical plan, provided that you request enrollment within 60 days after your other group health coverage ends.

SECTION 4 — COVERAGE LEVEL

Check who you will be covering. Your eligible dependents are your spouse and your unmarried children under age 23 who live with you in a regular parent-child relationship. (This includes children who are away at school.) If you are divorced, your children who do not live with you are eligible if you are legally required to support those children. Step children, foster children, and legally -adopted children are also eligible *provided they live with you* and are substantially dependent upon you for support and maintenance. Afffidavits of Dependency and legal documentation are required with enrollment forms for these cases if you have not provided this previously. On your initial application at the time of retirement, you may add eligible dependents; thereafter, dependents may be added within 60 days of the date of event, *i.e.*, marriage or birth of a child with an effective date of the date of the event. Otherwise, eligible dependents can be added in the future, with a 60 day waiting period. Coverage will be effective the 1st of the month following the 60 days of the receipt of your application.

Indicate whether you and/or your spouse/child are enrolled in Medicare Parts A and B. Be sure to list the effective dates of the enrollment. ***Proof of Medicare enrollment is required by the State Health Benefits Program.*** Please submit a photocopy of the Medicare card or a letter from Social Security confirming the effective dates of enrollment. Members receiving a Social Security Disability who become Medicare eligible, must be enrolled in the full Medicare program**—Part A *and* Part B in order to have coverage in the State Health Benefit Program** .

SECTION 5 — SPOUSE AND DEPENDENT INFORMATION

This section is used for members selecting Member & Spouse, Family or Parent & Child(ren) coverage. Please list your spouse's name, gender, date of birth, Social Security number, and if appropriate, Primary Care Physician ID#. Please also list the appropriate information for your eligible dependent children. If you are listing more than two children, please provide the required information for your other children on an additional sheet of paper and attach the sheet to the application.

The member's signature must appear at the bottom of the application along with the date completed. If Medicare proof or additional sheets are submitted with the application, check the box indicating such.

Return this **RETIRED STATUS APPLICATION** and all supporting documentation to:

NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. Box 299
TRENTON, NJ 08625-0299